Swing Bed Assessment

Patient: _____
Room: _____

Database

Medical Diagnoses:

Vital Signs: _____ Height_____ Weight_____
O^2 Sat:_____% ☐Room Air ☐____1/min via ☐Nasal Cannula ☐Other:_____

Prior Living Situation
☐Home Independent
☐Home w/ someone checking in
☐Living with a person who is: ☐Home full time ☐Out of home for work/other
☐Assisted Living ☐Long Term Care
☐Other:_____

Prior Level of Function:
☐Independent ☐Assist with ☐Self care ☐Cleaning ☐Shopping ☐Driving
☐Assist Other:_____ ☐Dependent

Current Health Conditions: **Care Plan? ☐YES ☐NO**

☐Cardiac Arrhythmia	☐Breathing Difficulty	☐Edema
☐Vertigo/syncope	☐Dehydration	☐Nausea/vomiting
☐Indigestion/reflux	☐Weight gain/loss	☐Constipation/diarrhea
☐Dysuria/retention	☐Bleeding:_____	☐Pain:_____

☐Skin Impairment:_____

Special Treatments & Procedures:		**Care Plan? ☐YES ☐NO**
☐O^2 Therapy	☐Nebulizers	☐Suction
☐IV Therapy	☐Telemetry	☐Tube feeding
☐BG Monitoring	☐Blood Transfusion	☐Pain control
☐Indwelling catheter	☐Wound care	☐Bowel/bladder prog.
☐Routine injections	☐IM ☐SC	
☐Monitoring acute medical condition: _____		
☐Monitoring medication effects: _____		
☐Other:_____		

Precautions: _____				
Allergies: _____				
Fall Risk:	☐Insignificant	☐Low	☐Medium	☐High
Weight Bearing Status:	☐Full	☐WBAT	☐Partial_____	
	☐Right LE	☐Left LE	☐TDWB	☐Non-WB

Swing Bed Assessment

Current Medications: ***Care Plan?*** ***☐ YES*** ***☐ NO***

_____ _____ _____
_____
_____ _____ _____
_____
_____ _____ _____
_____
_____ _____ _____
_____

Planning ***Care Plan?*** ***☐ YES*** ***☐ NO***

Discharge Plan: ☐ Patient ☐ Family: _____
☐ Home Independent ☐ Home with Home Health
☐ Home with someone checking in ☐ Home with some routine help
☐ Living with a person who is: ☐ Home full time ☐ out of home for work/other
☐ Assisted Living ☐ Long Term Care
☐ Other: _____

Rehabilitation Potential for Discharge Plan: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Discharge Plan Needs: ☐ Home Eval ☐ Patient Teaching
☐ Caregiver Teaching ☐ Home Health through _____
☐ Other: _____
☐ Equipment: _____

Cognition/Memory Care Plan? ☐ YES ☐ NO

Orientation: ☐ Person ☐ Day of Week ☐ Date ☐ Location ☐ Situation

Testing Results: ____ Mini Mental ____ Adapted FAST
____ Allen Cognitive Level
____ Other: _____

Memory: Short Term Memory: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Long Term Memory: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Decision Making: ☐ Independent ☐ Assist In New Situations Only
☐ Decision poor; requires cues, supervision
☐ Dependent on Another, rarely or never makes decisions

Swing Bed Assessment

Delirium
- ☐ Easily Distracted/difficulty paying attention
- ☐ Altered Perception or awareness of surroundings, such as hallucinations
- ☐ Disorganized, nonsensical, irrelevant speech
- ☐ Restless, frequent position changes, repetitive physical movement or calling out
- ☐ Lethargic, Staring into space, little body movement
- ☐ Mental function caries over the course of the day

Mood, Behavior, Psychosocial Functioning ***Care Plan? ☐ YES ☐ NO***

☐ Friendly ☐ Cooperative ☐ Quiet ☐ Withdrawn ☐ Tearful
☐ Anxious ☐ Agitated ☐ Calls Out ☐ Wanders ☐ Insomnia
☐ Verbally Abusive ☐ Physically Abusive ☐ Resists Care
☐ Socially Inappropriate ☐ Repetitive Statements ☐ Easily Annoyed
☐ Other: _____

Support System: ☐ Family ☐ Church ☐ Other: _____
Coping Skills: ☐ WFL ☐ Denial ☐ Other: _____

Communication/Hearing ***Care Plan? ☐ YES ☐ NO***

Speech/Language: ☐ WFL ☐ Aphasia ☐ Dysarthria ☐ Other: _____

Able to understand Others: ☐ WFL ☐ Usually ☐ Sometimes ☐ Rarely ☐ Unable

Hearing: ☐ WFL ☐ Hears Most 1:1 ☐ Significant Deficit
☐ Has Hearing Aides ☐ R ☐ L ☐ Uses Hearing Aides ☐ R ☐ L
☐ Reads Lips ☐ Written Messages ☐ Other: _____

Method of Communication: ☐ Verbal ☐ Writes Messages ☐ Gestures ☐ Other: _____

Able to make wants/needs known:
☐ WFL ☐ Usually ☐ Sometimes ☐ Rarely ☐ Unable

Visual Abilities ***Care Plan? ☐ YES ☐ NO***

Vision: ☐ WFL ☐ WFL with Correction ☐ Able to See Newsprint
☐ Able to See Headlines ☐ Able to See to Move about Room/Hospital
☐ Sees Shadows/Outlines ☐ Sees Nothing

Visual Aides: ☐ Glasses ☐ Contacts ☐ Magnifier _____x ☐ Large Print

Physical Functioning and Self-Care ***Care Plan? ☐ YES ☐ NO***

Physical Activity Tolerance: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Swing Bed Assessment

Bed Mobility: ☐Uses Bed Rails ☐Uses Trapeze
☐I ☐SBA ☐CGA ☐Min A ☐Mod A ☐Max A ☐Total A
☐A of 1 ☐A of 2 ☐A of 3+
Verbal Cues: ☐None ☐Min ☐Mod ☐Max

Transfer: ☐I ☐SBA ☐CGA ☐Min A ☐Mod A ☐Max A ☐Total A
☐A of 1 ☐A of 2 ☐A of 3+
Verbal Cues: ☐None ☐Min ☐Mod ☐Max
☐Stand Pivot ☐Mechanical Lift ☐Walker Used
☐Other:_____

Mobility: ☐Ambulatory ☐Non-Ambulatory
☐I ☐SBA ☐CGA ☐Min A ☐Mod A ☐Max A ☐Total A
☐A of 1 ☐A of 2 ☐A of 3+
Verbal Cues: ☐None ☐Min ☐Mod ☐Max

Mobility Device: ☐None ☐Cane ☐Quad Cane
☐Front Wheeled Walker ☐Seated Walker ☐Wheelchair
☐Other _____
☐New Device ☐Used Device for 90+ days

Dressing: ☐I ☐SBA ☐CGA ☐Min A ☐Mod A ☐Max A ☐Total A
☐A of 1 ☐A of 2
Verbal Cues: ☐None ☐Min ☐Mod ☐Max

Nutritional Status: ☐Excellent ☐Good ☐Fair ☐Poor
Eating/Intake: ☐I ☐SBA ☐CGA ☐Min A ☐Mod A Max A ☐Total A
☐Set Up ☐NPO
Verbal Cues: ☐None ☐Min ☐Mod ☐Max
Daily Intake Food_____% Fluid_____cc

Oral Status: ☐No Problem ☐Chewing Problem ☐Oral Pain
☐All Natural Teeth ☐Some Missing Teeth
☐Dentures ☐Upper ☐Lower ☐Edentulous, but no dentures used
Other: _____

Swallowing: ☐WFL ☐Dysphagia/Impaired
Verbal Cues: ☐None ☐Min ☐Mod ☐Max

Diet: Texture: ☐Regular ☐Mech. Soft ☐Pureed
Liquids: ☐Thin/Reg. ☐Nectar ☐Honey ☐Pudding
☐ADA_____cal. ☐Tube Feed ☐Other:_____

Swing Bed Assessment

Continence/Bowel & Bladder	☐Continent Bowel	☐Continent Bladder
	☐Occ. Inc. Bowel	☐Occ. Inc. Bladder
	☐Frequent Inc. Bowel	☐Frequent Inc. Bladder
	☐Ususally Inc. Bowel	☐Usually Inc. Bladder
	☐Catheter	☐Other:_____

Toilet Transfers:	☐I ☐SBA	☐CGA	☐Min A	☐Mod A	☐Max A	☐Total A
	☐A of 1	☐A of 2		☐A of 3+		
	Verbal Cues:	☐None	☐Min	☐Mod	☐Max	
	☐BSC ☐Toilet					
	☐Full Size Inc. Prod		☐Pull on Inc. Prod		☐Pad Inc. Prod	

Toilet Hygiene:	☐I ☐SBA	☐CGA	☐Min A	☐Mod A	☐Max A	☐Total A
	☐A of 1	☐A of 2	☐A of 3+			
	Verbal Cues:	☐None	☐Min	☐Mod	☐Max	

Groom/Hygiene:	☐I ☐SBA	☐CGA	☐Min A	☐Mod A	☐Max A	☐Total A
	☐A of 1	☐A of 2	☐A of 3+			
	Verbal Cues:	☐None	☐Min	☐Mod	☐Max	

Bathing:	☐I ☐SBA	☐CGA	☐Min A	☐Mod A	☐Max A	☐Total A
	☐A of 1	☐A of 2	☐A of 3+			
	Verbal Cues:	☐None	☐Min	☐Mod	☐Max	
	☐Stands	☐Shower Bench		☐Rolling Shower Chair		

Leisure Activity **Care Plan? ☐Yes ☐No**

Preferred Time:	☐Morning	☐Afternoon	☐Evening	☐None

General Interests:	☐Family/friends visits	☐Family/friends calls	☐Mail
	☐TV ☐Radio	☐Music Performances	
	☐Spiritual/Religious	☐Other:_____	

Source(s) of Information for Assessment:

☐Patient	☐Family	☐Direct Observation	☐Documentation
☐Staff Communication		☐Other: _____	

Signatures:

Patient _____ ___/___/___ _____ ___/___/___
Family _____ ___/___/___ _____ ___/___/___
_____ ___/___/___ _____ ___/___/___
_____ ___/___/___ _____ ___/___/___
_____ ___/___/___ _____ ___/___/___
_____ ___/___/___ _____ ___/___/___
_____ ___/___/___ _____ ___/___/___
_____ ___/___/___ _____ ___/___/___